

Division of Health Care Facilities

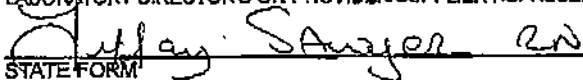
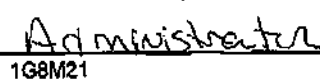
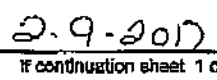
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2017
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF CLEVELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 2750 EXECUTIVE PARK PLACE CLEVELAND, TN 37312			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies During the life safety portion of the survey conducted on 1/23/17, no deficiencies were cited under 1200-8-6, standards for nursing homes.	N 002			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6000

1G8M21

If continuation sheet 1 of 1